IPDR6702				NORTH CAROLINA		PAGE	: 1	
	: 11/13/2005			S CHECKWRITE SUMMARY REPORT				
			С	HECKWRITE DATE: 11/15/2005				
				FINANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901		0	0	*** NO DATA TO REPORT ***				
3404901	SMOKY MOUNTAINM H/DD/SAS	0		NO DATA TO REPORT				
	n/ DD/ SAS							
		0	0		(	0	0	
3404904	WESTERN HIGHLAN	8329	183	CLAIM DENIED ATTENDING PROVIDE				
	DS LME			R CANNOT BE THE SAME AS				
				THE LMA				
		191	38	CLIENT ID NUMBER DOES NOT MATC				
		191	30	H PATIENT NAME	(	293	14765	1447
		8599	38	DETAIL NOT COVERED BY COMBINAT				
	+		+	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
	+		+	BENEFIT FROMUE.				
3404910	PATHWAYS	8599	17	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
	+	5404	7	SEVERE DUPLICATE: SAME ATTD PR			40.0	
	+			OV/PCODE/TOS/DOS/MOD	(	42	1341	108
		8518	6	CLAIM DENIED, SUBMITTED BEYOND				
				FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
3404912	CATAWBA COUNTYM	8932	34	CMTNC INELIGIBLE TO RECEIVE SE				
	ENTAL HEALT			RVICES IN IPRS.				
		8931	27	AMTNC INELIGIBLE TO RECEIVE SE	61	2 111	955	84
				RVICES IN IPRS.	0.4	111	933	04
		8599	11	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404913	MECKLENBURG COM	8518	257	CLAIM DENIED, SUBMITTED BEYOND				
	ENTAL HEALT			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	145	DETAIL NOT COVERED BY COMBINAT	68	618	1769	115
				ION OF RECIPIENT, PROVIDER AND	0.0	010	1703	113
				BENEFIT PACKAGE.				
		4.0	400					
	+	10	122	DIAGNOSIS OR SERVICE INVALID F  OR CLIENT AGE. VERIFY CID,		1		
	+			DIAGNOSIS, PROCEDURE CODE FOR		1		
		<u> </u>						
3404916	CROSSROADS BEHA	5404	1	SEVERE DUPLICATE: SAME ATTD PR		1		
	VIORAL HEAL			OV/PCODE/TOS/DOS/MOD		1		
	+		+					
		0	0			1	290	28
							230	
24040**		0510	116					L
3404917	CENTERPOINT HUM	8518	116	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR		1		
	AN SERVICES		+	FISCAL YEAR DOS (JULY 1 - JUNE		1	1	
	+							
		10	88	DIAGNOSIS OR SERVICE INVALID F	28	326	4026	370
				OR CLIENT AGE. VERIFY CID,				
	+			DIAGNOSIS, PROCEDURE CODE FOR				
	+	143	43	CLIENT ID NUMBER NOT ON STATE		1	1	
			1	ELIGIBILITY FILE				
						<u> </u>		
3404918	ROCKINGHAM CO M	U	0	*** NO DATA TO REPORT ***		1		
	ENTAL HEALT		+			1		
				+		1		1
		0	0			0	0	

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
IUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
8404919	GUILFORD CO MEN	8931	59	AMTNC INELIGIBLE TO RECEIVE SE				
	TAL HEALTHC			RVICES IN IPRS.				
		8599	53	DETAIL NOT COVERED BY COMBINAT		0.00		64.00
		0000	33	ION OF RECIPIENT, PROVIDER AND	67	262	6440	6178
				BENEFIT PACKAGE.				
		21	52	DUPLICATE OF CLAIM-SYSTEM				
404920	ALAMANCE CASWEL	8505	1225	CLAIM DENIED DUE TO INSUFFICIE				
	L AREA MH D			NT BUDGET				
		_						
		U	U		0	1225	1225	0
404921		5312	1739	PRIOR AUTHORIZED DOLLARS EXCEE				
	ORANGE PERSON C	3312	1733	DED				
	HATHAM AREA							
		8505	326	CLAIM DENIED DUE TO INSUFFICIE	30	3235	6801	3566
				NT BUDGET	30	2233	5301	5500
		8800	293	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
404922	THE DURHAM CENT	8329	161	CLAIM DENIED ATTENDING PROVIDE				
	ER			R CANNOT BE THE SAME AS				
				THE LMA				
		0505	100	OLLY DENIED DUE TO THOUSENED TO				
		8505	100	CLAIM DENIED DUE TO INSUFFICIE	0	263	263	0
				NT BUDGET				
		191	2	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
404923	FIVE COUNTY MH	79	155	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8329	71	CLAIM DENIED ATTENDING PROVIDE	9	376	3722	3346
				R CANNOT BE THE SAME AS				
				THE LMA				
		4.04	41					
		191	41	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
				n FAILDNI NAME				
404925	CAMPUTTI C COMPO	8534	540	SERVICE FACILITY LOCATION IS N				
	SANDHILLS CENTE R FOR MH/DD			OT A VALID IPRS ATTENDING				
	R FOR MIT/DD			PROVIDER. PLEASE VERIFY THE F				
		+						
		8536	497	ATTENDING PROVIDER TYPE AND SP	72	2185	10705	8520
				ECIALTY COMBINATION IS NOT	12	2100	20,00	3320
				VALID FOR SUBMITTED BILLING PR				
		79	383	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING	-			
				PROVIDER TYPE AND SPECIALTY IN				
			074					
104926	SOUTHEASTERN RE	21	274	DUPLICATE OF CLAIM-SYSTEM				
	G MENTAL HL	-						
		-						
		11	170	CLIENT NOT ELIGIBLE ON SERVICE			***	0.4
	1	<u> </u>	-	DATE	36	715	4182	3467
		-						l
		8535	134	SERVICE FACILITY LOCATION WAS				
		+		NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
104927	CUMBERLAND CO M	79	519	THIS SERVICE IS NOT PAYABLE TO				
	HC			YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		23	97	SERVICE REQUIRES PRIOR APPROVA	14	757	1413	656
				L				
		10	54	DIAGNOSIS OR SERVICE INVALID F				
		10	54	DIAGNOSIS OR SERVICE INVALID F  OR CLIENT AGE. VERIFY CID,  DIAGNOSIS, PROCEDURE CODE FOR				

		1	1		I		TOTAL	TOTA *
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS							
		0	0		0	0	0	
3404930		0	0	*** NO DATA TO REPORT ***				
3404930	JOHNSTON COUNTY MNTL HLTHC	0	0	NO DATA TO REPORT				
	MATE REINC							
		0	0		0	0	0	
3404931	WAKE CO HUM SVC	11	185	CLIENT NOT ELIGIBLE ON SERVICE				
	BILLING OF			DATE				
		0	0					
		0	0		0	185	199	1
3404932	RANDOLPH/SANDHI	0	0	*** NO DATA TO REPORT ***				
	LLS CO MH C							
		1	-					-
		0	0		0	0	n	
			<u> </u>					
2404022		101	-	CLATHE TO MINDED DODG NOT THE				
3404933	SOUTHEASTERN CT	191	69	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
	R FOR MH/DD	1						
		8599	21	DETAIL NOT COVERED BY COMBINAT	0	112	2913	280
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFIT PACKAGE.				
		21	14	DUPLICATE OF CLAIM-SYSTEM				
3404934		8534	73	SERVICE FACILITY LOCATION IS N				
3101331	ONSLOW CARTERET BEHAV HEAL	0004		OT A VALID IPRS ATTENDING				
	Danie IIII			PROVIDER. PLEASE VERIFY THE F				
		79	45	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING	0	149	175	2
				PROVIDER TYPE AND SPECIALTY IN				
		8535	15	SERVICE FACILITY LOCATION WAS				
				NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
				PLEASE RESUBMIT TOUR CLAIM WIT				
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR							
		0	0					
		1			0	0	0	<b> </b>
3404936	WILSON-GREENE M	8518	30	CLAIM DENIED, SUBMITTED BEYOND				
	ENTAL HEALT			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8933	1	ADTNC INELIGIBLE TO RECEIVE SE	1	32	53	2
				RVICES IN IPRS.				
		21	1	DUPLICATE OF CLAIM-SYSTEM				
	+	F-	l -	Of Castan Caucasts	1			
3404937	EDGECOMBE NASH	8599	716	DETAIL NOT COVERED BY COMBINAT				
	MNTL HLTH C	1	-	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				-
		8518	24	CLAIM DENIED, SUBMITTED BEYOND	0	752	868	11
				FILING TIMELIMIT. PRIOR				
	1			FISCAL YEAR DOS (JULY 1 - JUNE				
	_							
		21	10	DUPLICATE OF CLAIM-SYSTEM				
		21	10	DUPLICATE OF CLAIM-SYSTEM				
		21	10	DUPLICATE OF CLAIM-SYSTEM				

	1			1				
PROVIDER		HIGH DENIAL	NUMBER OF				TOTAL	TOTAL
PROVIDER NUMBER	DROUTDER WAVE	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
	PROVIDER NAME				DENIALS	DENIALS	FINALIZED	PAID
3404938	VGFW DBA RIVERS	0	0	*** NO DATA TO REPORT ***				
	TONE COUNSE							
		0	0		0	0	0	
3404939	NEUSE MENTAL HE	21	41	DUPLICATE OF CLAIM-SYSTEM				
	ALTH CENTER							
		0.000	0.7					
		8622	27	60 RESIDENTIAL LEVEL II TREATM	0	137	1054	91
				ENT RECEIVED, PA IS REQUIRED  FOR ADDITIONAL SERVICE.				
				FOR ADDITIONAL SERVICE.				
		8599	24	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404941	PITT CO MH/DD/S	0	0	*** NO DATA TO REPORT ***				
	AS CENTER							
	· ·							t
								t
		0	0		0	0	0	
3404942	ROANOKE CHOWANH	21	34	DUPLICATE OF CLAIM-SYSTEM				
	UMAN SERVIC							
		1	1					
		8599	25	DETAIL NOT COVERED BY COMBINAT	1	61	316	25
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		101		CLITTUE TO MUNICIPE DODG MOR MANG				
		191	1	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
								-
3404943		79	43	THIS SERVICE IS NOT PAYABLE TO				
3404343	ALBEMARLE MENTA			YOUR SUBMITTED BILLING				
	L HEALTH CE			PROVIDER TYPE AND SPECIALTY IN				
		8931	26	AMTNC INELIGIBLE TO RECEIVE SE	35	148	1127	97
				RVICES IN IPRS.		140	1117	
		5404	24	SEVERE DUPLICATE: SAME ATTD PR				
				OV/PCODE/TOS/DOS/MOD				
3404944	EASTPOINTE HUMA	191	81	CLIENT ID NUMBER DOES NOT MATC				
	N SERVICES			H PATIENT NAME				
		8599	31	DETAIL NOT COVERED BY COMBINAT	1	158	571	41
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				ļ
		100	25	OLIVER TO MEMORE WIGGINS				-
	+	120	25	CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT	+	+	+	
	+		1	AS A NEW CLAIM	-	<del>                                     </del>	<del> </del>	<del> </del>
	+		1	Company Control Control State of Control	-	<del>                                     </del>	<del> </del>	<del> </del>
3404946	POOTUTITE ADDAM	8599	37	DETAIL NOT COVERED BY COMBINAT		<del></del>		+
	FOOTHILLS AREAM ENTAL HEALT		+	ION OF RECIPIENT, PROVIDER AND		<del></del>	<del>                                     </del>	<del>                                     </del>
			1	BENEFIT PACKAGE.	<b>†</b>	<del>                                     </del>	<del>                                     </del>	<del>                                     </del>
	1	1	1					t
		191	21	CLIENT ID NUMBER DOES NOT MATC	20	87	634	54
				H PATIENT NAME				
		8935	20	ASTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
					1			<u> </u>
04040		0540	100					
3404957	TIDELAND MENTAL	8518	123	CLAIM DENIED, SUBMITTED BEYOND				
	HEALTH CTR	1		FILING TIMELIMIT. PRIOR				-
		1		FISCAL YEAR DOS (JULY 1 - JUNE				<b></b>
	+	8931		AMTNC INELIGIBLE TO RECEIVE SE	1	<del></del>	<del></del>	ļ
	-	0331	1	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	9	147	197	5
	-	1	+	NITCHO IN IFFG.	-	-	-	
	II.	1	+	<del> </del>	-	-	-	
								1
		8599	В	DETAIL NOT COVERED BY COMBINAT				+
		8599	8	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
		8599	8	ION OF RECIPIENT, PROVIDER AND				
		8599	8					

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404979	NEW RIVER AREAM	79	133	THIS SERVICE IS NOT PAYABLE TO				
	H/DD/SA PRO			YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8537	52	PROCEDURE IS NOT PAYABLE FOR Y	21	263	4586	4323
				OUR PROVIDER TYPE AND				
				SPECIALTY IN ACCORDANCE TO MEN				
		8599	28	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				